Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Pain Recovery Center

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-14-3286-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 1, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our office only provided and billed for 10 visits of therapy services/CPT 971120, which were preauthorized. All aspects of the claim form were correctly marked upon reconsideration. Payment continues to be denied by the insurance carrier."

Amount in Dispute: $196.18

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Per additional review: Authorization was eff 09/13/13 – 11/29/13 Physical therapy x 10 visits Lumbar 97110 Denial is correct."

Response Submitted by: Flahive, Ogden and Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 23, 2013	97110	$196.18	$161.86

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing
   - 12 – Submission/billing errors
   - 16 – Claim/service lacks information or has submission/billing errors
   - 19 – Precertification/authorization exceeded

Issues

1. Did the requestor submit an authorized claim?
2. What is the applicable fee guideline rule?
3. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed service as, "Precertification/authorization exceeded". Review of the submitted documentation finds;
    a) Notification of certification for 10 visits of lumbar 97110 from 09/13/13 – 11/29/13
    b) Request for reconsideration that detailed the dates of the 10 authorization
    c) Copy of corrected claim that contained required modifier and "G" codes.

    Therefore, the Division finds the carrier's denial is not supported. The disputed services will be reviewed per applicable rules and fee guidelines.
2. Per 28 Texas Administrative Code §134.203 (c) states in pertinent part, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor).
    - Procedure code 97110, service date October 23, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.45. The practice expense (PE) RVU of 0.48 multiplied by the PE GPCI of 0.912 is 0.43776. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.809 is 0.00809. The sum of 0.89585 is multiplied by the Division conversion factor of $55.30 for a MAR of $49.54. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure has the highest PE for this date. The first unit is paid at $49.54. The PE reduced rate is $37.44 at 3 units is $112.32. The total is $161.86.
3. The total allowable reimbursement for the services in dispute is $161.86. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $161.86. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $ 161.86.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $161.86 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February , 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.